

07827
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 07824
No. 253

1. PLACE OF DEATH: COUNTY <u>Duane Anne</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Chester</u> TOWN <u>Chester</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS _____		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md</u> COUNTY <u>Duane Anne</u> CITY (If outside corporate limits write RURAL and give nearest town) <u>Chester</u> TOWN <u>Chester</u> STREET ADDRESS _____ (If rural, give location)	
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3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Peter AUGUSTYNIAK (August)</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July 12 1957</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u>	8. DATE OF BIRTH: <u>Oct 20 1906</u>	9. AGE last birthday: <u>50</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME: <u>AUGUSTYNIAK</u>				14. MOTHER'S MAIDEN NAME: <u>Mary W. Szok</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.: <u>216-07-7610</u>		17. INFORMANT & ADDRESS: <u>Joseph (August) AUGUSTYNIAK</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Immediate cause (a) <u>Pulmonary Tuberculosis</u> DUE TO Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) _____		INTERVAL BETWEEN ONSET AND DEATH _____
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II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 19a. DATE OF OPERATION: _____ 19b. MAJOR FINDING OF OPERATION: _____				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)		
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE W. Henry Fisher CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 7/12-57
 DEPUTY MEDICAL EXAMINER ☐
 ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>July 15/57</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cem</u>	LOCATION (City, town, or county) (State) <u>Balta. County</u>
DATE REC'D BY LOCAL REG. <u>July 12, 1957</u>	REGISTRAR'S SIGNATURE <u>Elizabeth Taylor</u>		
24. FUNERAL DIRECTOR		ADDRESS <u>John M. Weber 401 S. Chester Hwy</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 17 1957

BUREAU V. 8

07828

CERTIFICATE OF DEATH

Reg. Dist. No.

07825257

1. PLACE OF DEATH a. COUNTY Queen Anne's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sudlersville				c. LENGTH OF STAY IN 1b 7 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Walraven Nursing Home				d. STREET ADDRESS (none)			
3. NAME OF DECEASED (Type or print) MARGARET FRANCES BOWERS				4. DATE OF DEATH Month July Day 2 Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1901	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady				10b. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John G. Ochs				14. MOTHER'S MAIDEN NAME Elizabeth Clark			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Grace Walters, 705 W. Cliveden Rd. Pikesville, Md.			
17. INFORMANT Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Corbaid Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Corbaid Arterial Sclerosis DUE TO (c) Chronic Myocarditis				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Previous Hypertension				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 27, 1957 to Aug 2, 1957 , that I last saw the deceased alive on Aug 1, 1957 , and that death occurred at CHH from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Dr. C. H. Metcalfe M.D.				Pikesville, Md. 7/2/57			
PHYSICIAN'S NAME (Type) Dr. C. H. Metcalfe				Sudlersville, Md. 7/2/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/5/57		22c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Vernon Lemmon				ADDRESS 4611 Park Hgts. Balto. Md.			
24a. REC'D BY REGISTRAR JUL 5 1957				24b. REGISTRAR'S SIGNATURE Edgar Lane			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957 5 JUL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07826
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>			c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Groesbeville, Md.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>E</u> Middle <u>Butler</u> Last				4. DATE OF DEATH Month <u>7</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) <u>62 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John L. Bryant</u>				14. MOTHER'S MAIDEN NAME <u>Mary Bryant</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Irene Willie</u> Address <u>N.Y., N.Y.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u></p> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>W. Henry Fisher</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/3/57</u>		<u>Bryans Cem.</u>		<u>Grasonville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Rashleigh & Sons, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>7/9/57</u>		24b. REGISTRAR'S SIGNATURE <u>John Aldridge</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH—BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: *John A. Smith*
 2. Sex: *Male*
 3. Age: *45*
 4. Date of Death: *July 10, 1957*
 5. Place of Death: *Home*
 6. Cause of Death: *Heart Disease*
 7. Manner of Death: *Natural*
 8. Signature of Medical Examiner: *[Signature]*
 9. Date of Examination: *July 10, 1957*

BUREAU V. 3

JUL 10 1957

RECEIVED

07830

CERTIFICATE OF DEATH

Reg. Dist. No. 254

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seasonsville</u>		c. LENGTH OF STAY IN 1b <u>life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Seasonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE JACOB JEWELL</u>				4. DATE OF DEATH Month Day Year <u>July 21 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 19-1891</u>		9. AGE (In years last birthday) <u>65</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>Keokuk Iowa 2 A Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Franklin Jewell</u>				14. MOTHER'S MAIDEN NAME <u>Cora Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-14-1808-A</u>		17. INFORMANT Address <u>Mr William L Jones (daughter) Seasonsville Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral thrombosis + uremia acute</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis, nephro sclerosis</u> DUE TO (c) <u>cerebral accident</u>						INTERVAL BETWEEN ONSET AND DEATH <u>July 19, 1957.</u> <u>Several years</u> <u>Oct. 1954.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>446X</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>St</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 19</u> , 19 <u>57</u> , to <u>July 21</u> , 19 <u>57</u> that I last saw the deceased alive on <u>July 20</u> , 19 <u>57</u> , and that death occurred at <u>11:59</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodor Sattelmaier</u> M.D.				ADDRESS (Street, city or town, state) <u>Stevensville Maryland</u>			
DATE SIGNED <u>7/22/57</u>							
PHYSICIAN'S NAME (Type) <u>Theodor SATTELMAYER M.D.</u>				<u>STEVENSVILLE Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 23, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chesterside</u>		22d. LOCATION (City, town, or county) (State) <u>Chesapeake Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Howard Batten</u>				ADDRESS <u>Bethesda Md.</u>		24a. REC'D BY REGISTRAR DATE <u>July 23-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Helen M. Aedridge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WESTLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

JUL 29 1957

RECEIVED

07831

CERTIFICATE OF DEATH

Reg. Dist. No.

07829
251

1. PLACE OF DEATH o. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sudlersville</u>				c. LENGTH OF STAY IN 1b <u>x2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Warraven Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Cook</u> Last <u>Kimble</u>				4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Fem.</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 6, 1873</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Cook</u>				14. MOTHER'S MAIDEN NAME <u>Lynch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Earl Chance--Church Hill, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac decompensation</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Arterial Sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 21, 1957</u> , to <u>July 20, 1957</u> , that I last saw the deceased alive on <u>July 15, 1957</u> , and that death occurred at <u>5:17</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. <u>C.H. METCALFE</u>		ADDRESS (Street, city or town, state) <u>Sudlersville Md.</u>		DATE SIGNED <u>7/22/57</u>	
PHYSICIAN'S NAME (Type) <u>C.H. METCALFE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>July 24</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Church Hill, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar R. Lane</u>				ADDRESS <u>Church Hill, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>7-22</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edgar R. Lane</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

JUL 24 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07830 254

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queentown</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>King</u> Middle <u>JR.</u> Last		4. DATE OF DEATH Month <u>7</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 10, 1940</u>
9. AGE (in years last birthday) <u>15</u> yrs.		IF UNDER 1 YEAR Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oliver King</u>		14. MOTHER'S MAIDEN NAME <u>Daisy E. Heath</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Daisy E. Heath, Queentown, Ind.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning (accidental)</u> 929.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>—</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>NA</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>W. Henry Fisher</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Centerville, Md.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/11/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bryant Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville, Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Charles, Easton, Ind.</u>		24a. REC'D BY REGISTRAR <u>17 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Allen Aldridge</u>		DATE	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: *William*
RESIDENCE: *1212 N. ...*
OCCUPATION: *...*

AGE: *35*
SEX: *Male*
DATE OF DEATH: *Oct 10, 1944*

CAUSE OF DEATH: *...*
MANNER OF DEATH: *...*

SIGNATURE OF EXAMINER: *...*
DATE: *...*

BUREAU V. S.

JUL 17 1957

RECEIVED

...
...

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07831

252

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRICE RURAL</u>				c. LENGTH OF STAY IN 1b <u>X2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HERBERT MURRAY</u>				4. DATE OF DEATH Month Day Year <u>JULY 6 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>BLACK</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 1884</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>UNKNOWN</u>			
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>unknown</u>			
16. SOCIAL SECURITY NO. <u>UNKNOWN</u>				17. INFORMANT <u>WELFARE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Coronary Disease of the Heart</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Hepatitis</u> DUE TO (c) <u>Alcoholic Cirrhosis</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>591X</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct 1, 1956</u> to <u>6/6, 1957</u> , that I last saw the deceased alive on <u>6-3-1957</u> , and that death occurred at <u>PRICE, Md.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H.F. McPherson</u>				DATE SIGNED <u>6/9/57</u>			
PHYSICIAN'S NAME (Type) <u>H.F. McPherson</u>				M.D. <u>Price, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-9 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CHURCH HILL</u>		22d. LOCATION (City, town, or county) (State) <u>CHURCH HILL MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>				ADDRESS <u>Church Hill</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 10 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Elaine Armstrong</u>							

BUREAU V. S.

10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07832
07834 CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crumpton</u>				c. LENGTH OF STAY IN 1b <u>x2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crumpton</u>			
				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Frank R. Reed</u>				4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept-18-1898</u>	
				9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Robert Reed</u>				14. MOTHER'S MAIDEN NAME <u>Frances Mary Casey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Frank Reed-Crumpton, md.</u>			
				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u> <u>177x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cachexia</u> DUE TO (c) <u>General Atherosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>cp</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 1</u> , 19 <u>57</u> , to <u>July 23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 19</u> , 19 <u>57</u> , and that death occurred on <u>July 23</u> , 19 <u>57</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C.H. METCALFE</u> M.D.				DATE SIGNED <u>July 24/57</u>			
PHYSICIAN'S NAME (Type) <u>C.H. METCALFE</u>				ADDRESS (Street, city or town, state) <u>SUDLERSVILLE MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>July 26</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Crumpton</u>		22d. LOCATION (City, town, or county) (State) <u>Crumpton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Kane</u>				ADDRESS <u>Church Hill, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>7-24</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edgar L. Kane</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD. CERTIFICATE OF DEATH

(Signature of Physician)
(Signature of Coroner)
General Secretary

10/1/1957
for 1
10/1/1957
10/1/1957

BUREAU V. E.

JUL 29 1957

RECEIVED

07835

CERTIFICATE OF DEATH

07833 251
 Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 1, Box 13</u>				d. STREET ADDRESS <u>R.F.D. 1, BOX 13</u>			
3. NAME OF DECEASED (Type or print) <u>Emma</u> First <u>Rochester</u> Middle Last				4. DATE OF DEATH Month <u>7</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 1, 1881</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Pauline Berthing</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>William Rochester, Church Hill, Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/1-</u> , 19 <u>57</u> to <u>7/1-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>11 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Henry Fisher</u>				ADDRESS (Street, city or town, state) <u>Centerville Md</u> DATE SIGNED <u>7/3-57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ewing Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Church Hill Rt. 1</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dorbell, Easton, Md</u> ADDRESS				24a. REC'D BY REGISTRAR <u>7/9/57</u>		24b. REGISTRAR'S SIGNATURE <u>Edgar L. Leno</u>	

CERTIFICATE OF DEATH

<p>NAME OF DECEASED <i>John A. Smith</i></p>		<p>DATE OF DEATH <i>July 10, 1957</i></p>	
<p>AGE <i>68</i></p>		<p>SEX <i>Male</i></p>	
<p>DATE OF BIRTH <i>March 15, 1889</i></p>		<p>PLACE OF BIRTH <i>St. Louis, Mo.</i></p>	
<p>RESIDENCE <i>1234 Elm St., Baltimore, Md.</i></p>		<p>OCCUPATION <i>Retired</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>IMMEDIATE CAUSE <i>Myocardial Infarction</i></p>	
<p>PERMANENT CAUSE <i>Coronary Artery Disease</i></p>		<p>INTERESTING FACTS <i>None</i></p>	
<p>SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i></p>		<p>SIGNATURE OF REGISTRAR <i>John A. Smith</i></p>	
<p>DATE OF SIGNATURE <i>July 10, 1957</i></p>		<p>DATE OF SIGNATURE <i>July 10, 1957</i></p>	

BUREAU V. S.

JUL 10 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 2,553

07936

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Centerville</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Centerville x 1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>/</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANCIS ROWE WOOD</u>				4. DATE OF DEATH <u>July 17 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 7-1907</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer, owner farming</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		10. BIRTHPLACE (State or foreign country) <u>Hellertown, Pennsylvania</u>		11. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Fred Wood</u>				14. MOTHER'S MAIDEN NAME <u>Ella Callahan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>2-17-36-1086</u>		17. INFORMANT <u>Mrs. Mabel Barren Wood</u> Address <u>Centerville Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Capture Myocardium</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Coronary Thrombosis</u> DUE TO <u>10 day</u> (c) <u>Coronary Sclerosis</u> DUE TO <u>years</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 11, 1957</u> , to <u>July 17, 1957</u> ; that I last saw the deceased alive on <u>July 17, 1957</u> , and that death occurred at <u>8:29</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Centerville Md.</u> DATE SIGNED <u>7-15-57</u> ACTUAL SIGNATURE <u>C. R. Layton</u> M.D. PHYSICIAN'S NAME (Type) <u>C. R. Layton</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>July 20-57</u>		22c. NAME OF CEMETERY OR-CREMATORY <u>Chestnutfield</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard Babin</u> ADDRESS <u>Barton Cross Centerville Md.</u>				24a. REC'D BY REGISTRAR DATE <u>7-19-57</u>		24b. REGISTRAR'S SIGNATURE <u>Elice Armstrong</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 22 1957

RECEIVED